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DATE: 4/05/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Bilateral Lumbar Epidural Steroid Injection at S1 with moderate sedation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is certified by The American Board of Anesthesiology and has over six years of experience.

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a gentleman whom sustained an industrial back injury when a pallet of X fell on him on XX/XX/XX.

XX/XX/XX: EMG Impression: Diabetic Polyneuropathy at multiple levels. Post compressive root injury at primarily the L4-5 level. In medical probability, related to prior workers injury, bilaterally. Severe S1 joint dysfunction related directly to prior workers injury or as part of the natural history of this workers injury.

XX/XX/XX: Sacroiliac Joint Injection was performed. Diagnoses: 338.4 Chronic Pain Syndrome. 722.83 Post Laminectomy Syndrome Lumbar Region. 720.2 Sacroiliitis NEC. 308.3 Other Acute Reactions To Stress.

XX/XX/XX: Follow up visit in which claimant describes no changes in his pain since his last visit. The claimant describes his pain as continuous and aching. He reports that walking, lifting, standing, weather changes, sitting, and bending exacerbate his pain. Sacroiliac joints are exquisitely tender to palpitation on the left and right. Reproduces concordant pain. Claimant reports experiencing 80% pain relief from the most recent SI joint injections on XX/XX/XX, with benefits lasting ongoing. The claimant reports improved analgesia and he is able to take less of his medications. Reports improved ADL's and ambulation.

XX/XX/XX: Sacroiliac Joint Injection performed. Diagnoses: 338.4 Chronic Pain Syndrome. 722.83 Post Laminectomy Syndrome. 720.2 Sacroiliitis NEC. Follow up in 2-3 weeks in office.

XX/XX/XX: Claimant was seen for a follow-up visit where he reports his most severe and primary source of pain is in his lower back. He reports his secondary pain is in his right knee. The claimant describes his pain as continuous and aching. He reports that walking, lifting, standing, weather changes, sitting, and bending exacerbate his pain. He reports that his pain is partially alleviated by injections, medications, and resting. He reports a 90% pain relief from his most recent SI joint injections done on XX/XX/XX. Follow up in 8 weeks.

XX/XX/XX: Claimant seen in the office for a follow up. He reports the following changes in pain since his last visit: "pain and numbness down the left leg". Sacroiliac joints are exquisitely tender to palpitation on the left and right. Reproduces concordant pain. Schedule bilateral SI joint injections under flouro. Consider future left sided LESI. 8 week follow up.

XX/XX/XX: Denial letter. Rationale: The request for bilateral SI joint injections was non-authorized. In my judgment, the clinical information provided does not establish the medical necessity of this request.

XX/XX/XX: Appeal letter states that the patient receives relief from the sacroiliac injections for about 5 months. The patient has had 90% of relief in his pain with the 12 injections that he has received since XXXX.

XX/XX/XX: Claimant was seen for a follow up where he states that his pain is now more severe. Sacroiliac joints are exquisitely tender to palpitation on the left and right. Reproduces concordant pain. Increase Lyrica 150 mg PO Q8 hours for pain #90. Claimant is currently on Lyrica 100 mg Q8 hours Plan was to schedule. D/C Mobic 15 mg. Transforaminal approach LESI at the bilateral SI.

XX/XX/XX: UR. Rationale: In my judgment, the clinical information provided does not establish the medical necessity of this request. This request is not supported by the Official Disability guidelines Low Back. His patient is status post epidural steroid injection at L5-S1 level in the past, but I have no report regarding specifics of objective measures of functional benefit or decrease in pain medication usage in relation to the epidural steroid injection to support repeat injection. Also, I do not appreciate, per guidelines criteria, that the patient has failed conservative treatment with physical methods, exercise, NSAIDs, and muscles relaxants prior to the requested procedure. Therefore, medical necessity has not been established.

XX/XX/XX: UR. Rationale: In my judgment, the clinical information provided does not establish the medical necessity of this request. This request is not supported by the Official Disability guidelines Low Back. As noted in the guidelines, the purpose of ESI is to reduce pain and inflammation, restoring ROM, and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long- term functional benefit. The guidelines also discuss that for repeat injection, 50-70% pain relief for at least 6-8 weeks should be documented from previous injection. In addition, medical necessity in accordance with the guidelines is also not established for the use of moderate sedation. This request is not established as medically necessary at this time.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous adverse decision is upheld. Per ODG, the purpose of ESI is to reduce pain and inflammation, restoring ROM, and thereby facilitating progress in more active treatment programs, and avoiding surgery. However, this treatment alone offers no significant long- term functional benefit. The guidelines also discuss that for repeat injection, 50-70% pain relief for at least 6-8 weeks should be documented from previous injection. In addition, medical necessity in accordance with the guidelines is also not established for the use of moderate sedation. Therefore, this request is not medically necessary and is non-certified.

PER ODG:

Criteria for the use of Epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

(1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.

(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, muscle relaxants & neuropathic drugs).

(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.

(4) *Diagnostic Phase:* At the time of initial use of an ESI (formally referred to as the "diagnostic phase" as initial injections

indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections.
(5) No more than two nerve root levels should be injected using transforaminal blocks.
(6) No more than one interlaminar level should be injected at one session.
(7) *Therapeutic phase:* If after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)
(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.
(9) Current research does not support a routine use of a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.
(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.
(11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**